RESIDENTIAL TREATMENT STANDARDS

PURPOSE

The purpose of these standards is to provide direction and guidance to the Children and Family Services (CFS) programs regarding the structure and application of residential treatment services for children with SED. These standards are intended to achieve statewide consistency in the development and application of CMH core services and shall be implemented in the context of all applicable laws, rules and policies.

INTRODUCTION

Residential treatment facilities (RTC) fall at the most restrictive end of the spectrum in the continuum of care for children with Serious Emotional Disturbance. A RTC is a 24 hour, licensed facility offering mental health treatment. For purposes of these standards, RTC shall be inclusive of group homes and children's treatment facilities. Programs vary widely in their philosophical approaches to treatment. In the past, stays in such facilities were long term, sometimes as long as a year or more. Recently, under managed care, programs are serving children in much shorter time frames.

Concerns related to children in RTCs largely focus on costliness, failure to learn behavior needed in the community, possibility of trauma associated with the separation from the family, difficulty reentering the family, abandonment by the family and learning of antisocial behaviors from exposure to other disturbed children. (Mental Health: A Report of the Surgeon General, 1999 – Chapter 3)

Although RTCs are used by about 8% of treated children, nearly one-fourth of the national outlay for children's mental health treatment is for care in these settings. To further complicate matters, there is only weak evidence for their effectiveness. (Mental Health: A Report of the Surgeon General, 1999 – Chapter 3)

That being said, RTC remains a vital component of the full spectrum of care that Idaho desires to develop. Thus, the question becomes, for those children who must be treated in residential treatment facilities, "how can we increase the chances of a positive outcome?" Various studies have found different combinations of factors that increase positive outcomes. However, one consistent factor focuses on discharge planning/aftercare. The majority of studies looking at outcomes define communication and coordination between the RTC, family, school, juvenile justice, and community based service providers as paramount to positive outcomes. So, coordination of discharge planning and aftercare must be addressed in our standards.

CORE VALUES

- The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

- The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

- Children with emotional disturbance should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.

- Children with emotional disturbance should receive services within the least restrictive, most normative environment that is clinically appropriate.

- Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

- The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

- The needs of children and families can more effectively be met through flexible funding strategies than through categorical funding restricted to the most expensive resources.

STANDARDS

1. **Each region shall identify a Regional Placement Authority (RPA).**

2. **Children placed in residential treatment shall meet the CMH eligibility criteria of serious emotional disturbance (SED); if placement is necessary for a child not meeting the SED target population, the variance shall be documented by the Regional Placement Authority.**

3. **The CW social worker and the CMH clinician shall jointly manage children placed in residential treatment that meet the CMH target population and that are in the custody of the DHW through CW. Clearly delineated roles and responsibilities shall be documented in the service plan, including the documentation of the primary case manager.**

PRE-PLACEMENT STANDARDS

4. **Each child considered for RTC shall be staffed prior to placement by individuals to be determined by the RPA; including, but not limited to, the placing worker(s), child (if appropriate) and the child's parent or legal guardian. Any variance to this standard shall be documented the FOCUS automated information system.**

5. **The pre-placement staffing shall be documented in writing and shall focus on the following areas for determining necessity.**

    a. **Less restrictive options and documentation of past failures in lesser restrictive placements.**
    b. **History of hospitalizations**
    c. **Specific behaviors requiring RTC**
    d. **Outcome expectations**
    e. **Criminal Behavior**

6. **The program manager or designee shall be responsible for final authorization of placement.**

7. **A comprehensive assessment shall be completed by a CMH clinician prior to any considerations of placement in residential treatment. If a current comprehensive assessment already exists in the child's file, the CMH clinician shall update that assessment. Any variance to this standard shall be documented.**

8. **All pertinent documentation necessary for placement of a child in RTC shall be completed prior to placement according to rules and policies (see FOCUS standards manual).**

9. **In state placements shall be considered and ruled out prior to consideration of any out-of-state placement.**

10. **All out-of-state placements in RTC are subject to ICPC regulations.**

11. **For children in the custody of DHW through child welfare that meet CMH eligibility requirements, the Alternate Care Plan shall be completed by the CW social worker, the CMH clinician, the child's parents/guardian, and others as appropriate working cooperatively.**

12. **In cases of children in the custody of DHW through child welfare, that do not meet CMH eligibility criteria, the alternate care plan shall be the responsibility of the CW social worker making the placement and a CMH clinician may assist.**

13. **For children being placed in residential treatment through CMH under a voluntary agreement, the CMH clinician shall complete the Alternate Care Plan.**

14. **A service plan must be completed and signed by all parties prior to placement. The service plan will include, at a minimum:**

    a. **Concrete and measurable objectives.**

b. **Level of Parental Involvement necessary for Positive Outcomes**
c. **Targeted behaviors to be addressed in RTC**
d. **Initial discharge planning**
e. **Cultural considerations that need addressed**
f. **Visitation schedule for parent and staff**
g. **Designation of primary case manager**

PLACEMENT STANDARDS

15. **If CW is also involved with the family, the primary worker for the RTC placement will be identified.**

16. **The identified primary worker will be responsible for maintaining contact with the child, their family, and the treatment facility and communicating any information to the other worker.**

17. **ASFA guidelines shall be followed for any child, whether in the CW or CMH program, that is placed in RTC.**

18. **120-Day Reviews shall be conducted face to face and include participation by the parent, all involved DHW staff and the child if possible. The 120-Day Review shall result in written documentation of progress.**

AFTERCARE STANDARDS

19. **Discharge planning shall be the responsibility of the primary worker working cooperatively with the family and shall begin prior to placement.**

20. **RTC placement shall be closed in FOCUS within two (2) working days of the discharge date.**

21. **A discharge plan shall be completed 30-days prior to discharge; the primary worker shall be responsible for coordinating the discharge plan which shall include the participation of all applicable parties:**

    a. **Family**
    b. **Education**
    c. **Juvenile Justice**
    d. **Local CMH Councils**
    e. **Other relevant parties**

22. **Any variance to these standards shall be documented and approved by division administration, unless otherwise noted.**

23. Each region shall establish residential treamtent service delivery goals and shall annually submit a plan and timeline to achieve those goals to division administration for approval.